TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	18-0007	Maine
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION:	
	SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
Centers for Medicare and Medicaid Services		
Department of Health and Human Services	9/4/18	
Department of Heatin and Haman Services	9/4/10	
5. TYPE OF PLAN MATERIAL (Check One):		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
		each amenament)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
1902 (a)(10)(A)(i)(VIII)	a. FFY 2018 increase: accounted for in ME.18-0006	
42 CFR 435.119	b. FFY 2019 increase: accounted for	r in ME.18-0006
		TO CEDED DY 134
8. PAGE NUMBER OF THE PLAN SECTION OR	9. PAGE NUMBER OF THE SUPERSEDED PLAN	
ATTACHMENT:	SECTION OR ATTACHMENT (If Applicable):	
Cumulament 10 to Attachment 2.6A	New	
Supplement 18 to Attachment 2.6A	New	
10. SUBJECT OF AMENDMENT:		
Methodology for Identification of Applicable FMAP Rates for Exp	pansion of Medicaid coverage to the 1	902(a)(10)(A)(i)(VIII)
eligibility group		
11. GOVERNOR'S REVIEW (Check One):		
COVERNOR'S OFFICE REPORTED NO COMMENT	OTHER A	AS SPECIFIED:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT	U UTHER, A	IS SPECIFIED.
_	☐ OTHER, A	AS SPECIFIED.
	_	S SPECIFIED.
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMIT	ГТАL	AS SPECIFIED.
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	_	AS SPECIFIED.
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMIT 12. SIGNATURE OF STATE AGENCY OFFICIAL:	ΓΤΑL  16. RETURN TO:	AS SPECIFIED.
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